Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2017	2017_690130_0004	022364-17	Resident Quality Inspection

Licensee/Titulaire de permis

LIUNA LOCAL 837 NURSING HOME(ANCASTER) CORPORATION
44 HUGHSON STREET SOUTH HAMILTON ON L8N 2A7

Long-Term Care Home/Foyer de soins de longue durée

REGINA GARDENS
536 UPPER PARADISE ROAD HAMILTON ON L9C 5E3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

GILLIAN TRACEY (130), CATHIE ROBITAILLE (536), CATHY FEDIASH (214), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 27, 28, 29, October 2, 3, 4, 5, 2017.

The following critical incident inspections were conducted concurrently with the RQI: 011414-17, 031679-16.
The following complaint inspections were conducted concurrently with the RQI: 033549-16, 009037-17
The following onsite inquiries were conducted concurrently with the RQI: 027454-16, 0004336-17, 006523-17, 007269-17, 010329-17, 010734-17 and 015096-17.

During this inspection the home was toured, staff, residents and families were interviewed, clinical records and relevant policies and procedures were reviewed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Personal Support Worker Coordinator, Resident Assessment Instrument (RAI) Coordinator, Food and Nutrition Manager (FNM), registered staff, personal support workers, President of the Residents' Council, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A review of a resident #100's plan of care contained information that staff were to provide dietary interventions at meal times: when entrée not liked at lunch or dinner. A review of the Diet/Serving binder (updated September 19, 2017) contained no information for dietary intervention and food restrictions for meals as stated in the resident's "care plan".

On a specified date in 2017, staff #301 indicated that the Diet/Serving binder was used as the main source of information by dietary staff when serving meals to residents. Staff #301 also indicated that the resident had certain preferences and confirmed that there was no information in the Diet/Serving binder related to resident #100's food preferences and restrictions. On a specified date in 2017, the FNM confirmed that there was no information in the Diet/Serving binder about resident #100's dietary interventions, food

preferences and restrictions, as identified in the resident's "care plan".

The staff in the home did not collaborate with each other, so that their assessments of the resident were integrated and were consistent with and complemented each other. (Inspector # 632). [s. 6. (4) (b)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of a Critical Incident System (CIS) submitted by the home in 2017, indicated that resident #100 was alleged to have abused resident #060.

A review of resident #100's clinical record, indicated that on a specified date in 2017, Behavioural Supports Ontario (BSO) assessed the resident and determined that a specific intervention should be put in place so that staff could monitor the resident. An observation conducted on an identified date in 2017, revealed that the intervention was not put in place.

An interview with registered staff #300 confirmed that the intervention was not being used anymore and that a different intervention was in place. The staff member confirmed that the resident's plan of care was not reviewed and revised when their care needs changed.

PLEASE NOTE: This non-compliance was issued as a result of a Critical Incident System Inspection #011414-17 that was conducted concurrently with the RQI Inspection. (Inspector #214)

B) The home's investigation notes revealed that on an identified date in 2017, staff #110 observed that resident #014 was not their "normal self". The staff observed that the resident was exhibiting unusual signs and symptoms; however, they did not immediately report their observations to the registered staff in charge. Shortly after, staff #110 stated they returned to the resident's room, while their co-worker told registered staff #115 that the resident was still not their normal self. Staff #110 observed signs and symptoms which were not the resident's usual disposition. When interviewed, staff #110 stated that usually the resident required a one person assisted transfer; however, the resident required two staff to transfer on this particular day, due to their symptoms. Staff #110 stated in an interview that registered staff#115 assessed the resident when becoming

aware of the resident's condition.

Recreation assistant staff #113 stated in an interview that they arrived on the unit at a specified time to gather residents for a program, and that they observed the resident sleeping in their chair. Staff #113 stated that resident #014 had their glasses folded over their eyes and one leg fallen over to the side. When the resident woke, staff #113 asked them if they still wanted to attend the program; the resident replied yes. Staff #113 reported their observations to registered staff #115. The interviews and investigation notes revealed that registered staff #115 later took resident #014 to the program, and stayed to assist the resident with eating as the resident was not attempting to eat on their own. Resident #014's plan of care, which the home refers to as the care plan and interviews conducted, revealed that the resident usually fed them self. Staff #113 stated in an interview that when the resident was at the program , sitting at a table, that they kept rolling their wheelchair back and forth which was not their usual behaviour.

The home's investigation notes and interviews conducted revealed that registered staff #115 was made aware of the resident's status, returned to the unit with the resident after dinner, repeated an assessment and contacted the resident's Substitute Decision Maker (SDM). When interviewed, the SDM stated they arrived and noted that the resident had unusual symptoms. The registered staff was unable to be reached for interview; however, their progress note dated in 2017, at a specified time, revealed that the resident had complained of a specific symptom and that a vital sign assessment was the only assessment conducted.

The Administrator acknowledged that the nurse did not do an assessment of the resident based on the signs and symptoms resident was exhibiting.

On an identified date in 2017, the registered staff failed to ensure that resident #014 was assessed when their care needs changed. (Inspector #536). [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or when care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A review of the home's abuse policy titled, "Abuse Allegations and Follow-Up (LTC-CA-WQ-100-05- 02 with a revised date of July 2016) indicated the following:

i) Physical Sexual Abuse: Depending on the nature of the sexual abuse, transport the resident to local hospital with a Sexual Assault Program, if applicable, complete and document a Head to Toe physical assessment prior to transfer.

A review of a Critical Incident System (CIS) submitted by the home, indicated that resident #100 was alleged to have abused resident #060 on an identified date in 2017.

Actions taken as identified in the CIS, indicated that the two residents were separated; staff checked on resident #060 and a head to toe assessment was given afterwards.

A review of the resident's clinical records indicated that a head to toe assessment had not been completed. This was confirmed during an interview with registered staff #300 and the RAI Coordinator in 2017.

An interview with the DOC and the ADOC in 2017, confirmed that resident #060 had not required a transfer to the hospital; however, it was expected that a head to toe assessment was to have been completed. The DOC confirmed that the home had not complied with their abuse policy. (Inspector 214). [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) A review of the Medication Incident Reports for 2017, revealed that medication incidents reported on two identified dates in 2017 for resident #102 and resident #034, were not reported to the physician. A medication incident reported on a third date in 2017, for resident #091, revealed that neither the SDM nor the physician were notified of the incident.

The DOC confirmed that not all reported medication incidents were consistently reported to the resident's SDM, if any, the Medical Director and the attending physician. (Inspector #130). [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, had a response been made to the person who made the complaint, indicating:
i. what the licensee had done to resolve the complaint, or
ii. that the licensee believed the complaint to be unfounded and the reasons for the belief.

A review of a complaint submitted to the home by a family member of resident #095 revealed specific food dislikes due to their food preferences and cultural traditions and requested that specific food allowances be made when specific items were served to the resident. On an identified date in 2017, the Administrator recalled conversation with the family member and indicated that they misunderstood the family member's request assuming that it was related to the menu or specific food items recipe. The Administrator indicated that no response had been made to the person who made a complaint. (Inspector #632). [s. 101. (1) 3.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time.

A) On September 29, 2017, the medication stock room was observed and noted to contain 37 boxes containing 10 Dimenhydrinate Suppositories per box and 13 bottles containing 1000 Senokot per bottle. The DOC confirmed that the amount of Dimenhydrinate and Senokot on hand exceeded the home's three month usage. (Inspector #130). [s. 124.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

A) On September 29, 2017, the DOC confirmed that the stock room where government stock medications were stored, was accessible by key to the PSW Care Coordinator.

The DOC confirmed that the PSW Care Coordinator was not a registered staff and should not have access to the room where medications were stored. (Inspector #130). [s. 130. 2.]

Issued on this 28th day of November, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.